A MANAGED CARE/PUBLIC HEALTH PARTNERSHIP: OPPORTUNITIES IN NEW YORK CITY'S MEDICAID PROGRAM

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The term *managed care* has come to encompass a wide variety of arrangements for accessing, delivering, and financing health care. From health maintenance organizations and point-of-service products to paid provider organizations and physician practice management firms, the health care landscape has undergone a fundamental transformation in the last decade. Today, the majority of Americans are enrolled in some form of managed health care.[1]

Because there is considerable concern and scrutiny among stakeholders—patients, providers, plans, purchasers, advocacy groups, government—that managed care not mean "less care" or "inferior care," the spread of managed care has been accompanied by a concomitant rise in accountability for the care that is delivered.

Managed care can be credited with accelerating the demand for increased accountability. The professional literature is rife with discussions of and strategies for defining, developing, measuring, monitoring, assessing, promoting, improving, and rewarding quality standards, performance indicators, and outcomes. Clearly, creating a realistic and workable set of meaningful standards, indicators, and outcomes is no easy task.

On July 1, 1998, the New York City Department of Health entered into this arena when it assumed responsibility for the city's Medicaid managed care program. This occurred because health insurance and access to care are funda-

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mentally public health issues. Through its Division of Health Care Access, the Department of Health became the purchaser of health care services for the beneficiaries enrolled in the 18 health plans serving the city's Medicaid managed care population.

With this new responsibility came an unprecedented opportunity to incorporate public health concerns into managed care activities. As the contract holder, the New York City Department of Health, in partnership with New York State, has the potential to have an impact on the types of services made available and the practice standards used to deliver those services. In addition, the department can exercise some leverage if contractual obligations are not met.

Bringing together medicine and public health is not a new idea. There has been little headway made in what has been described in the seminal 1988 Institute of Medicine report, *The Future of Public Health,* as their "uneasy relationship."[2] In the past half-century, there have been numerous efforts to bridge the divide between the two fields of expertise.[3] None of these efforts was accepted widely, but having the Medicaid managed care program under the aegis of the Department of Health has presented a new and unique opportunity to bridge the divide.

A new partnership has been forged. The challenge is to expand the area of overlap between the respective missions of Medicaid managed care organizations and the New York City Department of Health. The health department's administration of Medicaid managed care involves executing contracts and amendments; reviewing, assessing, and monitoring the plans' performance; and enforcing the terms and conditions of these contracts. The contracts also provide an opportunity to highlight the public health responsibilities of the managed care organizations.

The health department's contracts with the Medicaid managed care plans include an appendix, "Guidelines for Coordination with Public Health Agencies." This comprehensive document details the plans' contractual obligations for addressing public health priorities, including immunization, lead poisoning prevention, domestic violence prevention, communicable disease surveillance, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), tuberculosis, sexually transmitted diseases, and maternal and child health. The guidelines charge the plans with developing and implementing protocols for standards of care, communicating those protocols to their providers, and verifying that their providers are using those protocols.

The guidelines also require each managed care organization to participate in the Community Health Workgroup—a collaboration with the New York City Department of Health to identify and select priority public health issues and to develop, implement, and evaluate appropriate comprehensive interventions to

address these issues. The first priority area of focus selected by the Community Health Workgroup was childhood asthma.

In addition to the city's oversight of contractual obligations, the plans are held accountable by the state. The State Department of Health produces an annual report on quality, access, utilization, and descriptive data collected from the managed care plans in New York. Quality Assurance Reporting Requirements (QARR) is a series of measures designed to examine managed care plan performance in key areas. The measures are adopted from the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) with additional measures added to address public health issues of particular significance in New York, such as lead screening of children.

A preliminary assessment of data from the State Department of Health's *1998 QARR: a Report on Managed Care*[4] was performed. These findings should be interpreted with care because some measures can be affected by collection and reporting errors, as well as changes in the way rates are defined and calculated. Finally, while some changes may not be significant statistically, the direction of the changes suggests a trend.

The assessment of the data shows that the majority of performance indicators for the Medicaid managed care plans in New York State have shown improvement. Of the 18 "effectiveness-of-care" indicators included in the report, 12 (two-thirds) improved from 1997 to 1998. Indicators in this group include HIV testing of pregnant women and the use of appropriate medications for people with asthma.

Of the 12 effectiveness-of-care measures for which there is data for three years (1996–1998), four (one-third) have shown consistent improvement. Indicators in this group include risk-adjusted low birth weight, children receiving comprehensive well-child visits in the first 15 months of life, adolescents screened or counseled for tobacco use, and women screened for cervical cancer.

The publication of QARR scores may serve as an incentive to managed care organizations to perform well because members can use this information to select a plan in which to enroll. The city may also use QARR scores and other measures of quality to make informed decisions about contracting with Medicaid managed care plans. Also under consideration is the possibility of rewarding plans with QARR scores that improve and are significantly better than state averages.

The era of increased accountability is still quite new. As some researchers have pointed out, it is important to continue to ask questions about the reliability and validity of tools for measuring performance, such as QARR.[5] Do they measure the right things? Are they accurate and understandable? Finally, do they correlate

with improved health outcomes and increased customer satisfaction? Answers to these and other critical questions about measuring managed care performance are much needed.

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